

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

Ladenman
35013

State File No.

FILED NOV 2 - 1953

BIRTH NO. _____ REG. DIST. NO. 38 PRIMARY REG. DIST. NO. 3006 Registrar's No. 280

1. PLACE OF DEATH a. COUNTY <u>Boone</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Boone</u> <u>0105</u>	
b. CITY OR TOWN <u>Columbia</u>		c. CITY OR TOWN <u>Columbia</u>	d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. LENGTH OF STAY (in this place)		e. STREET ADDRESS (If rural, give location) <u>824 Range Line</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Boone County Hospital</u>			

3. NAME OF DECEASED (Type or Print)	a. (First) <u>WILLIAM</u>	b. (Middle) <u>ROBERT</u>	c. (Last) <u>MAXWELL</u>	4. DATE OF DEATH (Month) (Day) (Year) <u>Oct. 26, 1953</u>
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5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>Aug. 14, 1874</u>	9. AGE (In years last birthday) <u>79</u>	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Farmer</u>	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and State or Foreign Country) <u>Boone County, Missouri</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
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13a. FATHER'S NAME <u>J.H.H. Maxwell</u>	13b. MOTHER'S MAIDEN NAME <u>Sally Cochran</u>	14. NAME OF HUSBAND OR WIFE <u>Paulina Buckmaster Maxwell</u>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>	16. SOCIAL SECURITY NO.	17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Mrs. Geo. R. Simmons, Kansas City, Mo.</u>
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18. CAUSE OF DEATH. Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH <u>14 days</u>
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Cerebral hemorrhage with</u>		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>with hemiplegia</u> DUE TO (c) <u>Cerebral arteriosclerosis</u>		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Fracture femur</u>		14 days	

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION <u>331 X F</u>	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>Home</u>	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) <u>Columbia Boone Mo</u>
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) <u>10 12 53</u> m.	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	21f. HOW DID INJURY OCCUR? <u>Fell after cerebral hemorrhage</u>
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22. I hereby certify that I attended the deceased from 10-12, 1953, to 10-26 1953 that I last saw the deceased alive on 10-26, 1953, and that death occurred at 1:30P m., from the causes and on the date stated above.

23a. SIGNATURE <u>R.P. Lademan, MD</u> (Degree or title)	23b. ADDRESS <u>16 N. 10th, Columbia</u>	23c. DATE SIGNED <u>10-29-53</u>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	24b. DATE <u>Oct. 28, 1953</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Columbia Cemetery</u>	24d. LOCATION (City, town, or county) (State) <u>Columbia, Missouri.</u>
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DATE REC'D BY LOCAL REG. <u>Oct 29 1953</u>	REGISTRAR'S SIGNATURE <u>Mrs R.E. Palmer</u> <u>315</u>	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Parsons Funeral Service, Columbia, Mo</u>
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed
by me, or by, Student Embalmer No.....
working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed *Tom McHarg*.....

Licensed Embalmer No. *406*.....

P. O. Address *Columbia*.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).
If embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.